

Small Group Market Report

Maryland Health Care Commission

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Genesis of CSHBP

- Health Care Reform Act of 1993
 - Modified community rating- no medical underwriting
 - Guaranteed issue
 - Guaranteed renewal
 - Comprehensive Coverage
 - Standard plan to facilitate price comparison among carriers

Recent Trends

Participation in the SGM

- Employer participation has declined 14% since 1999 (58,495 > 51,022)
 - Approximately 78,000 (60%) of small employers do not participate in the small group market
- Employee participation has declined 12% since 1998 (489,473 > 429,431)
 - Recently, the decline among employees has stopped, but the decline in dependent coverage continues

Costs of coverage

- The cost of health insurance continues to outpace substantially the rise in wages and GDP

Carriers in the SGM

- The number of carriers in the SGM has declined dramatically due to both mergers and departures
 - Participating carriers have declined from 37 in 1995 to 8 in 2006
 - The top two insurers have a combined market share of about 86% of the small group market
- New entrants are unlikely due to:
 - Dominance and substantial reserves of the non-profit carrier
 - Difficulty negotiating network agreements; provider reimbursement rates are substantially above those of the dominant carrier
 - CSHBP has a highly prescriptive design, making it difficult to “import” benefit designs offered elsewhere

Reasons for Study

HB 579 (2007) - Identify potential opportunities for change in the SGM that would encourage employer and employee participation both through new participants and retention of existing participants

- Continuing concerns about decreased employer and employee participation
- Continuing concerns about competition in the small group market (high concentration among carriers)
- Continuing concerns that the cost of health insurance continues to outpace substantially the rise in wages and GDP

The MHCC contracted with Mercer, its actuary, to conduct the study

Guiding Principles

Mercer tasked to look at each of the policy components of the CSHBP from an actuarial perspective and opine on opportunities to make effective change that will encourage the following:

- new employers and employees to participate
- retention of existing employers and employees
- the young and healthy to participate
- dependents to participate
- the prudent use of benefits
- maintaining a healthy lifestyle
- the use of care management

Policy Components of the Comprehensive Standard Health Benefit Plan

- Comprehensive set of required services (few mandates excluded)
- Standard plan designs to facilitate comparison
 - HMO, HDHMO, EPO, POS, PPO, HMO/HSA, PPO/HSA
 - Prescribes both the structure of the benefit and the maximum cost-sharing
 - Benefit floor is the actuarial equivalent of a Federally-Qualified HMO based on the cost and experience in the Maryland SGM
 - Ceiling- premiums w/o riders not to exceed 10% of Maryland average annual wage
- Riders are used - must enhance the benefits offered
- Modified community rating
 - Age and geography only
 - 2.8 : 1 ratio of highest to lowest (+40%,-50%)
- Guaranteed issue and renewal
- No pre-existing requirements

Premium Floors and Ceiling

- **Premium floor is currently based on an actuarial floor**
 - Each core benefit design currently must have an actuarial value at least equal to the value of benefits required to be offered by a federally qualified HMO, based on the cost and experience of the SGM in Maryland
 - Because several key services are not required of an FQHMO, the basic unridered policies are above the floor
 - However, the floor limits design flexibility, since enough benefits have to be included to meet or exceed the floor
 - The prescriptive nature of this design process may limit innovation
 - The prescriptive designs may make it difficult for national carriers to enter the SGM, since plans they offer elsewhere may not meet the specific design requirements of the CSHBP
- **Premium floor also defined by required covered services**
 - Commission has adopted all but 5 of the 42 mandates
 - Requiring specific services be covered may make it more difficult for plans to develop robust value-based incentives and medical necessity criteria to constrain escalating health care expenditures
- **Ceiling**
 - “Affordability Standard” - average cost of the standard plans must not exceed 10% of Maryland average wage
 - Doesn’t really measure affordability since:
 - It measures only the premium, not the substantial out of pocket expenses
 - It is based on policies that no one purchases

Average Premium: 2005 v. 2006

HMO

		Employee only	% Change	Family	% Change
HMO - Core	2005	\$3,132		\$8,347	
	2006	\$2,883	- 8%	\$7,616	- 9%
HMO - w/riders	2005	\$3,557		\$9,479	
	2006	\$3,889	+ 9%	\$10,275	+ 8%

Average Premium: 2005 v. 2006

PPO

		Employee only	% Change	Family	% Change
PPO - Core	2005	\$2,643		\$6,506	
	2006	\$2,433	- 8%	\$6,470	- 0.5%
PPO - w/riders	2005	\$4,663		\$11,479	
	2006	\$4,999	+ 7%	\$13,296	+ 16%

CSHBP Design Options Proposed by Mercer

CSHBP benefits and cost

- Minimize or eliminate the floor and ceiling

Rating Principles

- Broaden the rating band to better reflect age-related risk
- Incorporate gender
 - Increases rates for young women, lowers rates for older women
 - Lowers rates for young men, increases rates for older men
- Allow rates to include a modest rate adjustment based on health factors
 - Allow +/- 5% to 10% variation from age and geography-based rates
- Allow a more substantial initial rate adjustment for new businesses entering the SGM, but blend to pure modified community rate over several years
 - Attracts low risk participants to strengthen the pool
 - Charges groups more that enter the pool only when they are at higher than average risk

"Without some adjustment to the current rating policy, the CSHBP will remain attractive to older less healthy groups and less attractive to younger healthier groups"

Expanding the SGM

- Increase the small group size from 2-50 to 2-75

Preexisting condition exclusion

- Allow HIPAA compliant pre-existing condition exclusions

Education and price comparison

- Create a web based information and education resource for the SGM

Additional CSHBP Design Options Considered

Benefit designs

- specify a separate in-network deductible, out-of-network deductible, in-network out-of-pocket maximum and out-of-network out-of-pocket maximum
- maintain the existing core benefits, but allow employers to rider down as well as up
- design a standard benefit more like the most popular benefit plans actually purchased, then allow employers to rider down as well as up
- define a narrower set of core benefits and allow health insurers to offer wraparound benefits
- do away with the concept of prescriptive benefits and cost-sharing designs

Increasing employee choice

- require health plans to allow employers to offer at least two plan choices

Other changes

- require employers to establish Section 125 premium conversion plans
- establish a mandatory reinsurance program for the SGM
- Increase the minimum medical loss ratio of health plans from 75% to 80% (Loss ratios are currently between 79% and 81%)

Expanding the SGM to Include Businesses with 2 to 100 Employees

SGM would benefit from an expanded pool, but...

- Most employers with 51-100 employees would not want modified community rating, especially if their demographics are younger and their experience is better than average
- Large groups are generally offered greater flexibility regarding benefit design than in the small group market
 - Unlikely that flexibility would exist to the same degree in a merged market
- Administrative costs are lower in the 51-100 market
- Employer groups with 75-100 relatively healthy employees would have a greater incentive to self-insure, leaving sicker and/or older groups in the combined market
- Initial premium rise of 2%-5% for large employers
- Could result in large group insurers leaving the market because of rating restrictions

Expanding the Small Group Market

Redefine SGM to include self-employed - NOT recommended

- There are numerous studies documenting that including the self-employed in the SGM will tend to increase small employer premiums
- Only 12 states have enacted laws defining small groups to include “groups of one”
- Allowing self-employed individuals back into the SGM would exert upward pressure on rates

Merge SGM with State Employee Pool – NOT recommended

Merge SGM and non-group market – Substantial issues

- Currently, Maryland’s individual market operates under very different principles:
 - No guaranteed issue
 - Fully underwritten – rate of denials, pre-ex condition exclusions, or raised premiums range from 15% to 40% of applications
 - MHIP backstops the underwritten individual market, and its deficit is funded by all payers (not just the individual market insurers)
- Because of risk selection, non-group premiums are lower than in the SGM
- Outcome of merging these two markets is unpredictable
- Using modified community rating in the entire merged market would lead to a premium spiral, unless coupled with an individual mandate
- Merging the SGM and non-group market in other states resulted in insurers exiting the market

Most Promising Options for Future Consideration

- Replace prescriptive plan design (“comprehensive, standard”) with greater design flexibility
 - Minimize or eliminate the floor and ceiling concept
 - Eliminate the “standard” plans
- Consider modifying the current modified community rating
 - Widen the rating bands based on age
 - Allow premiums to reflect health factors on initial entry, transitioning to modified community rating over several years
 - Apply HIPAA portability rules to pre-existing conditions exclusion
- Expand the SGM to include employers with 2-75 employees
- Improve information by implementing web based “Virtual Compare” for the SGM